Bedford Health Department
2021 - 2022 Registration Form for COVID-19 Booster Vaccination

The completion of this form is necessary for every vaccine recipient. Please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * / /	Age*	Sex:(Circle)* Male Female Transgender Other
Ethnicity: (Circle) Hispanic or Latino / Not Hispanic or Latino	Race: (Circle) Asian Black Native American Pacific Islander White Other		
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Check all that apply to the person being vaccinated:

Received two doses of COVID-19 Vaccine before today?	☐ No ☐ Yes
If yes, Date of last Dose: _____ Type/Brand of Covid Vaccine: _____	
Have an allergy to any medication, food, pet, venom, vaccine, polyethylene glycol (PEG), polysorbate or latex?	
List all allergies: _____	
Feeling sick today?	☐ No ☐ Yes
Have a bleeding disorder or are they using a blood thinner?	☐ No ☐ Yes
Received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes
Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐ No ☐ Yes
Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies?	☐ No ☐ Yes
Have a history of heparin-inducted thrombocytopenia (HIT)?	☐ No ☐ Yes
Have a history of Guillain-Barre Syndrome (GBS)?	☐ No ☐ Yes
Have a history of myocarditis or pericarditis?	☐ No ☐ Yes
Is pregnant or breastfeeding?	☐ No ☐ Yes
Have dermal fillers?	☐ No ☐ Yes

I acknowledge I will receive the COVID-19 Booster Vaccine and I have received the Vaccine Information Fact Sheet, dated May 17, 2022.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

For Clinical Staff only:

Date of Service	Vaccine Name	Vaccine Mfgr.	Lot Number	Exp. Date	Dose (ml)	Inject. Route	Injection Site (Circle)	VIFS Date	Date VIS Given	State Supplied	Preserv Free
						IM	R Arm L Arm R Leg L Leg	Pfizer 5/17/22		Y N	Y N

Provider Name: **Bedford Health Department** MDPH Provider PIN#: **10119**

Provider Address: **Town of Bedford- BOH 12 Mudge Way, Bedford, MA, 01730**

Signature of Vaccine Administrator: _____ Date: _____